Champonnière has also operated upon eleven cases of epigastric hernia, one patient having two hernias of this variety. As contrasted with umbilical hernia, this form of hernia never tends to materially increase in size, and, instead of being almost painless, is usually the cause of severe distress, with vomiting and a variety of intestinal lesions which are difficult to explain in many cases. The palliative treatment of this condition has little to offer. In only one case of those observed was a bandage able to give any relief.

The operation is easy and the results are efficacious and satisfactory. The hernial orifice should be freely incised; the sac drawn out and opened, and the omentum which it contains detached and excised. After ligating the pedicle of the sac it is cut off as much as possible. The walls of the wound are then sutured together; first a line of sutures in the serosa, and then a second tier is introduced to strengthen the first. The skin wound may be closed with or without drainage.

This operation was in all cases followed by the best results; the wound remained firm, and in no case was there a recurrence of the hernia. The difference in character between these two forms of hernia, which are such near neighbors in point of position, is quite remarkable.—*Transactions of the French Congress of Surgery*, 1894.

HENRY P. DE FOREST (Brooklyn).

V. Telescopic Anastomosis of Sigmoid Flexure of Colon into Lateral Opening in Rectum. By HOWARD A. KELLY, M.D. (Baltimore). The patient was a woman, twenty-two years of age, suffering from an artificial anus, sequel to an attempt to enucleate and remove the uterine appendages which were involved in an extensive mass of pelvic exudate, in the course of which attempt, after one tube and ovary had been removed, a section of a contracted and thickened sigmoid flexure had been mistaken for the remaining tube and had been tied off and excised. When this mistake was recognized, the cut ends of gut were sewed into the abdominal wound and the operation abandoned. Two months later the patient came

under Dr. Kelly's care, who relieved her by the following procedure: The scar containing the sigmoid and rectal orifices was dissected out; the pelvic organs were enucleated, and the remaining tube and ovary and the uterus were excised. The redundant contracted upper portion of the rectum was cut away and its lumen closed by suture. The free end of the sigmoid was then caught with six long silk traction sutures passed through the peritoneal and muscular coats, entering about a half a centimetre from the edge of the incision, and emerging on the incision, without piercing the mucosa. The walls of the bowel were from three to four millimetres thick and somewhat rigid, without the flaccidity of the normal sigmoid.

An oblique incision was then made into the rectum on the pelvic floor just above and behind the vagina close to the cervix, below the lower end of the stricture. This incision, made through the abdominal incision, was about three centimetres long, and directed from before backward from left to right, the greater part lying to the left. With a pair of long artery forceps passed through the anus and ampulla and out through the incision into the pelvic cavity, the six traction sutures were caught in a bunch and pulled down and out of the anus, drawing the sigmoid into the rectal incision, which was held open with forceps to facilitate the entrance. The bowel was then kept from slipping back into the pelvis by grasping the traction sutures in the heel of the bite of a forceps lying across the anus in the gluteal furrow. A rectal examination showed that about one centimetre of the sigmoid projected into the rectum. The fit of bowel into bowel at the incision as seen from above was such a snug one that the line of division between sigmoid and rectum could not be detected.

Fixation of the anastomosis by means of a few sutures uniting the sigmoid to the rectum, passed on the pelvic side, could not be carried out, as there was too little room between the bowel and the pelvic walls to permit the use of either needle-holder or needle.

The pelvis was washed out and a gauze pack inserted around the sigmoid, and another up among the inflamed bowels and brought out

at the lower angle of the incision, which was closed to this point. The patient made an excellent recovery and has since had normal bowel function. At no time did she pass fecal matter in any other way than per anum.—*Johns Hopkins Hospital Bulletin*, February, 1895.

EXTREMITIES.

Direct Digital Compression of the Common Iliac Vessels in Disarticulation of the Hip. By M. CHALOT (Toulouse). The author has devised a method of disarticulation of the hip-joint by means of which the danger of hæmorrhage is reduced to the same degree as in other amputations. A button-hole incision is first made through the abdominal parietes just inside of the anterior superior spine of the ilium; the peritoneum is stripped up and pushed aside, and the fingers are passed beneath this reflected layer as far as the angle formed by the psoas muscle and the sacral promontory; there the termination of the common iliac artery is found and compressed. The disarticulation can then be done in whatever manner is deemed best under the circumstances. It should be remembered that the upper end of the divided femoral vein may bleed from reflux, notwithstanding the fact that the common iliac vein be compressed at the same time as the artery.

Chalot carried out this plan in the case of a man, twenty-one years of age, who was suffering from an encephaloid sarcoma involving the fleshy part of the thigh. The execution was easy, and the patient was cured.—*Transactions of the French Congress of Surgery*, 1894.

HENRY P. DE FOREST (Brooklyn).

MALE GENITO-URINARY ORGANS.

I. The Diagnosis and Treatment of Malignant Tumors of the Kidneys in Adults. By Dr. THORKILD ROVSING (Copenhagen). Since the first malignant tumor of the kidney was removed by Kocher, eighteen years ago, the operation has been done 150 times, with a mortality from the operation of 50 to 66 per cent.